ASPETTI PSICHIATRICI DELLA SINDROME VERTIGINOSA

ADA

FRANCIA

Roma 05/05/2018

AGENDA

- VERTIGINI FUNZIONALI«PSICOGENE»
- VERTIGINI IN COMORBIDITA’
- QUADRI PSICOPATOLOGICI PIU’ C0MUNI
- TRATTI DI PERSONALITA’ E S.VERTIGINOSE
- CENNI DI TERAPIA

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Functional Neurologic Disorders
M. Hallett, J. Stone, and A. Carson, Editors
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Chapter 37

Functional (psychogenic) dizziness

M. DIETERICH[1,2]*, J.P. STAAB[3], AND T. BRANDT[2]

Functional and psychiatric disorders that cause vestibular symptoms (i.e., vertigo, unsteadiness, and dizziness) are common. In fact, they are more common than many well-known structural vestibular disorders. Neurologists and otologists are more likely to encounter patients with vestibular symptoms due to persistent postural-perceptual dizziness or panic disorder than Ménière's disease or bilateral vestibular loss. Successful approaches to identifying functional and psychiatric causes of vestibular symptoms can be incorporated into existing practices without much difficulty. The greatest challenge is to set aside dichotomous thinking that strongly emphasizes investigations of structural diseases in favor of a three-pronged approach that assesses structural, functional, and psychiatric disorders simultaneously.

The pathophysiologic mechanisms underlying functional and psychiatric causes of vestibular symptoms are better understood than many clinicians realize. Research methods such as advanced posturographic analysis and functional brain imaging will push this knowledge further in the next few years. Treatment plans that include patient education, vestibular rehabilitation, cognitive and behavioral therapies, and medications substantially reduce morbidity and offer the potential for sustained remission when applied systematically. Diagnostic and therapeutic approaches are necessarily multidisciplinary in nature, but they are well within the purview of collaborative care teams or networks of clinicians coordinated with the neurologists and otologists whom patients consult first.

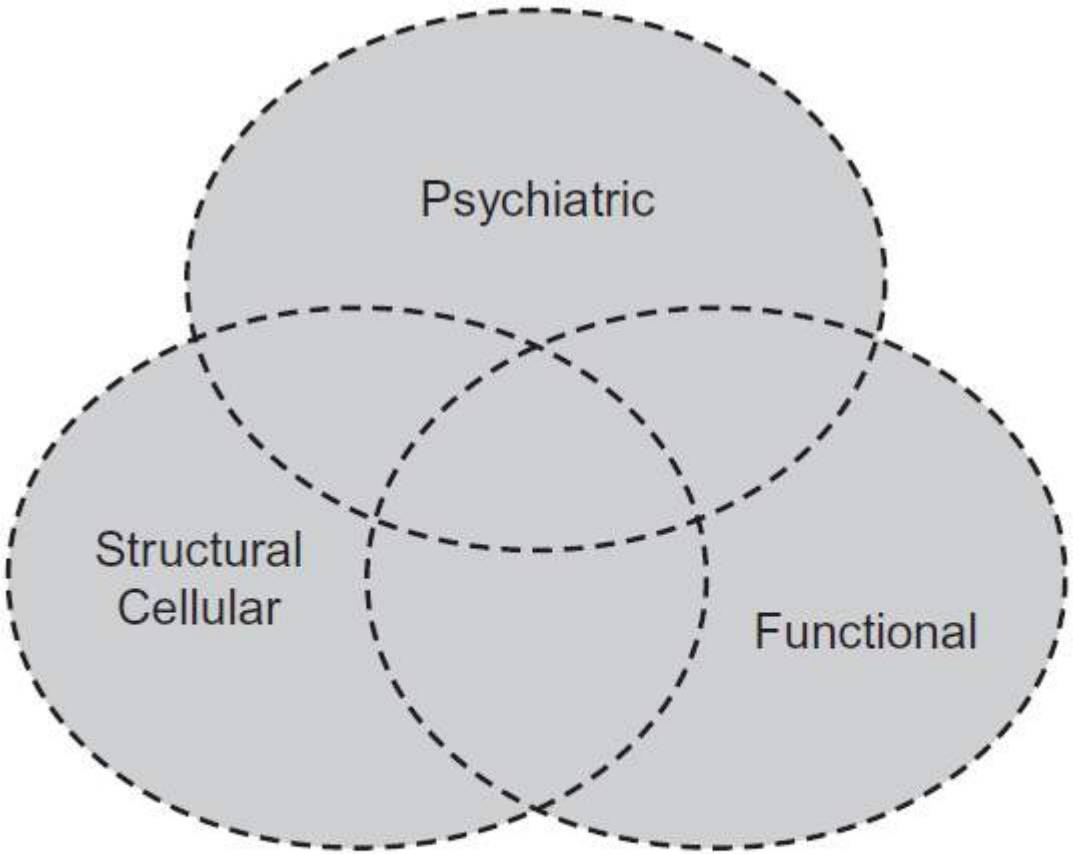


Fig. 37.1. General diagnostic classification of vestibular disorders. Structural/cellular, somatic/functional, and psychiatric disorders may independently cause vestibular symptoms. They also may coexist in any combination of primary, secondary, and coexisting conditions.

Signs and symptoms in acute and chronic syndromes of structural, functional, and psychiatric vestibular disorders

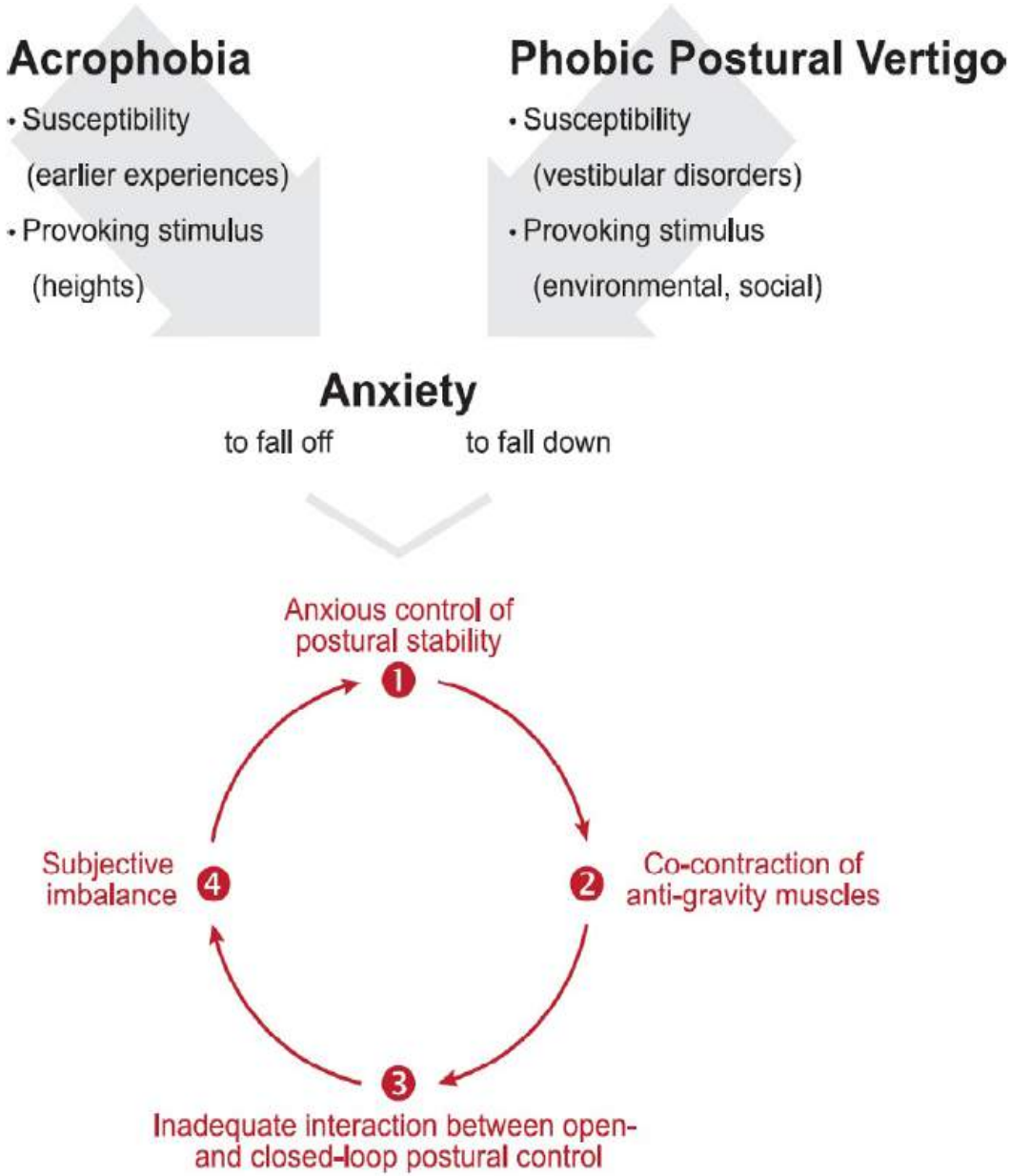
		Structural disorders	Functional disorders	Psychiatric disorders
Acute or episodic syndromes	Vestibular symptoms	Vertigo attacks		Dizziness Unsteadiness
	Motion sensitivity	Vertigo in specific positions Vertigo with rapid head tilts or turns		Fear of provocative motion
	Aural symptoms	Fluctuating hearing loss Unilateral tinnitus		
	Autonomic and vegetative symptoms	Nausea Emesis	Mild queasiness without emesis Mild diaphoresis, tremulousness	Chest pain, palpitations, dyspnea, tremulousness, paresthesias
	Posture and gait abnormalities	Direction-specific pulsion or falls Drop attacks Ataxia	Variable gait and stance deficits Excessive upper-body motion	Excessive caution
	Emotional symptoms			Fear of falling or heights Fear of becoming incapacitated or accidentally harming others
Chronic syndromes	Vestibular symptoms	Unsteadiness Dizziness	Unsteadiness Dizziness	Unsteadiness Dizziness
	Motion sensitivity	Vertigo, unsteadiness, or oscillopsia with rapid head movements	Unsteadiness or dizziness with motion of self in any direction or movement in the environment	Avoidance of provocative motion environments

Signs and symptoms in acute and chronic syndromes of structural, functional, and psychiatric vestibular disorders

	Structural disorders	Functional disorders	Psychiatric disorders
Aural symptoms	Progressive hearing loss Unilateral tinnitus		Variable tinnitus
Autonomic and vegetative symptoms		Chronic fatigue	Tension, restlessness, insomnia, fatigue, weight change Cognitive complaints
Postural and gait abnormalities	Progressive decline in gait speed or fluidity Gradually increasing frequency of falls	Postural unsteadiness or dizziness Variable sensations of impending falls, toppling over, or floating off the ground	Excessive caution Unnecessary use of gait aids
Emotional symptoms			Catastrophic worries about consequences of symptoms Demoralization or sadness Pessimism or hopelessness

PHOBIC POSTURAL VERTIGO

- «POSTURAL DIZZINES» OBIETTIVITA'NEGATIVA
- MARCATO SENSO DI INSTABILITA' E PAURA DI CADERE
- EPISODI «SITUAZIONALI»
- RISOLUZIONE CON ATTIVITA' MOTORIE E DISTRAENTI
- …..TANTI ALTRI SINTOMI
- TRATTO DI PERSONALITA' OSSESSIVO


Acrophobia
• Susceptibility
(earlier experiences)
• Provoking stimulus
(heights)
Phobic Postural Vertigo
• Susceptibility
(vestibular disorders)
• Provoking stimulus
(environmental, social)
Anxiety
to fall off
to fall down
Anxious control of postural stability
1
2
Co-contraction of anti-gravity muscles
3
Inadequate interaction between open- and closed-loop postural control
4
Subjective imbalance

Chronic dizziness: the interface between psychiatry and neuro-otology

Jeffrey P. Staab

Current Opinion in Neurology 2006, 19:41–48

Table 2 Definition of chronic subjective dizziness

Physical symptoms	*Subjective dizziness and imbalance*: Persistent (≥ 3 months) sensations of nonvertiginous dizziness, light-headedness, heavy-headedness, or subjective imbalance that are present on most days. *Hypersensitivity to motion*: Chronic (≥ 3 months) hypersensitivity to one's own motion, which is not direction specific, and to the movements of objects in the environment. *Visual vertigo*: Exacerbation of symptoms in settings with complex visual stimuli such as grocery stores or shopping malls or when performing precision visual tasks (e.g. reading or using a computer).
Neuro-otologic evaluation	*History and exam*: Absence of active physical neurotologic illnesses, definite medical conditions, or medications that may cause dizziness. Past history may include episodes of true vertigo or ataxia as long as the conditions causing those symptoms have resolved. *Neuroimaging*: Normal radiographic imaging of the brain. *Balance function tests*: Normal or nondiagnostic findings. Included in this criterion are patients who have recovered clinically from past neurotologic illnesses and demonstrate fully compensated, vestibular deficits on balance function tests and those with isolated test abnormalities that cannot explain the presenting symptoms.

Table 3 Characteristics of chronic subjective dizziness

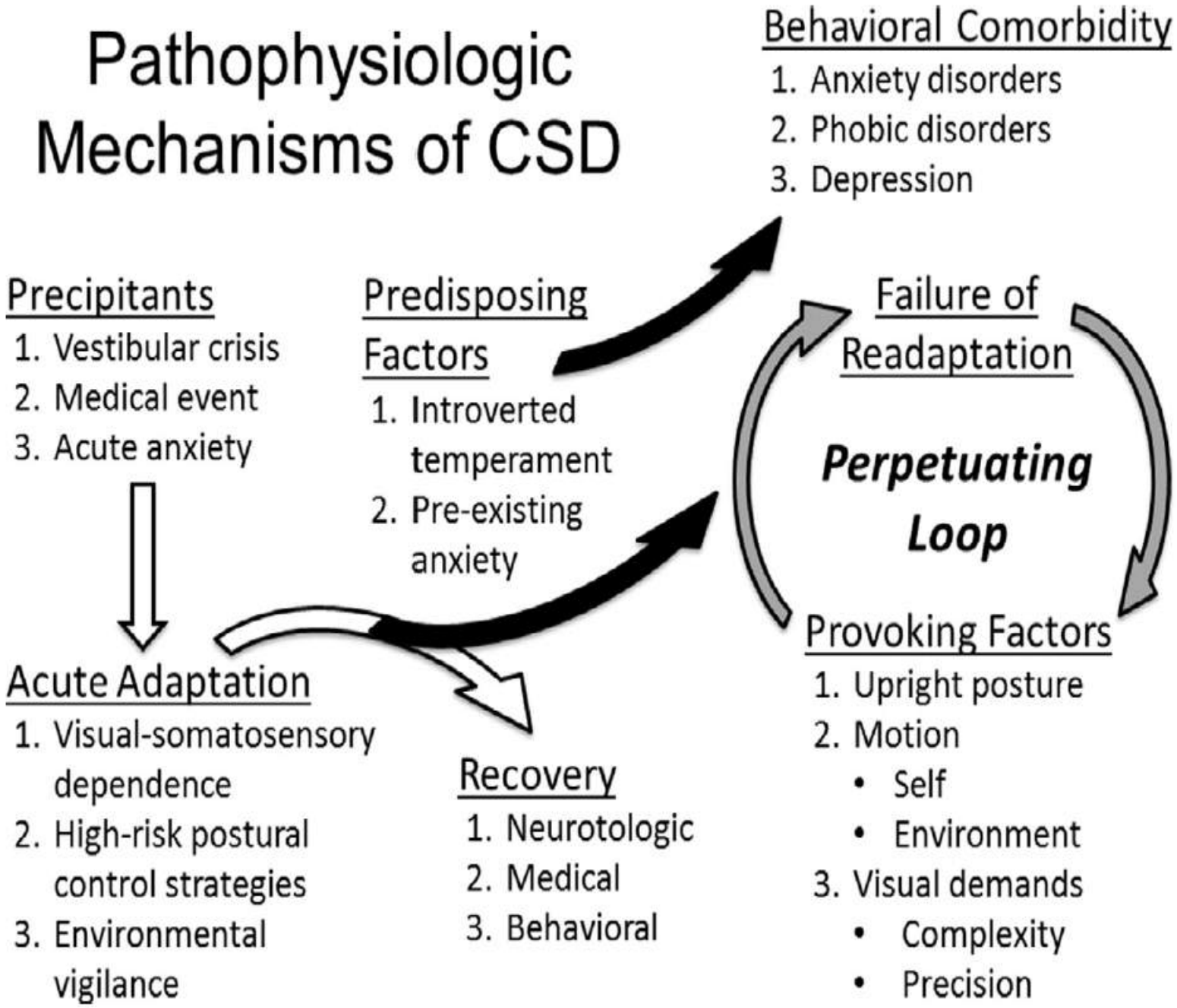
	Predisposing factors	Precipitants	Physical symptoms	Psychological morbidity	Sustaining factors	Treatments
Otogenic CSD	Phobic/anxious temperament?	Neuro-otologic or other medical event	SDI HM VV	NA, AA, PA Occasional panic	Conditioning Somatic preoccupation	Psychoeducation, SSRIs, CBT, VBRT
Psychogenic CSD	Phobic/anxious temperament	Panic attack	SDI HM VV	AA, PA Panic attacks	Conditioning Catastrophic cognitions	Psychoeducation, SSRIs, CBT, VBRT
Interactive CSD	Pre-existing anxiety, neurotic temperament	Neuro-otologic or other medical event	SDI HM VV	AA, PA Panic attacks Generalized anxiety	Conditioning Activated anxiety	Psychoeducation, SSRIs, CBT, VBRT

AA, anticipatory anxiety; CBT, cognitive behavioral therapy; CSD, chronic subjective dizziness; HM, hypersensitivity to motion stimuli; NA, noxious avoidance; PA, phobic avoidance; SDI, subjective dizziness/imbalance; SSRIs, selective serotonin reuptake inhibitors; VBRT, vestibular and balance rehabilitation therapy; VV, visual vertigo.

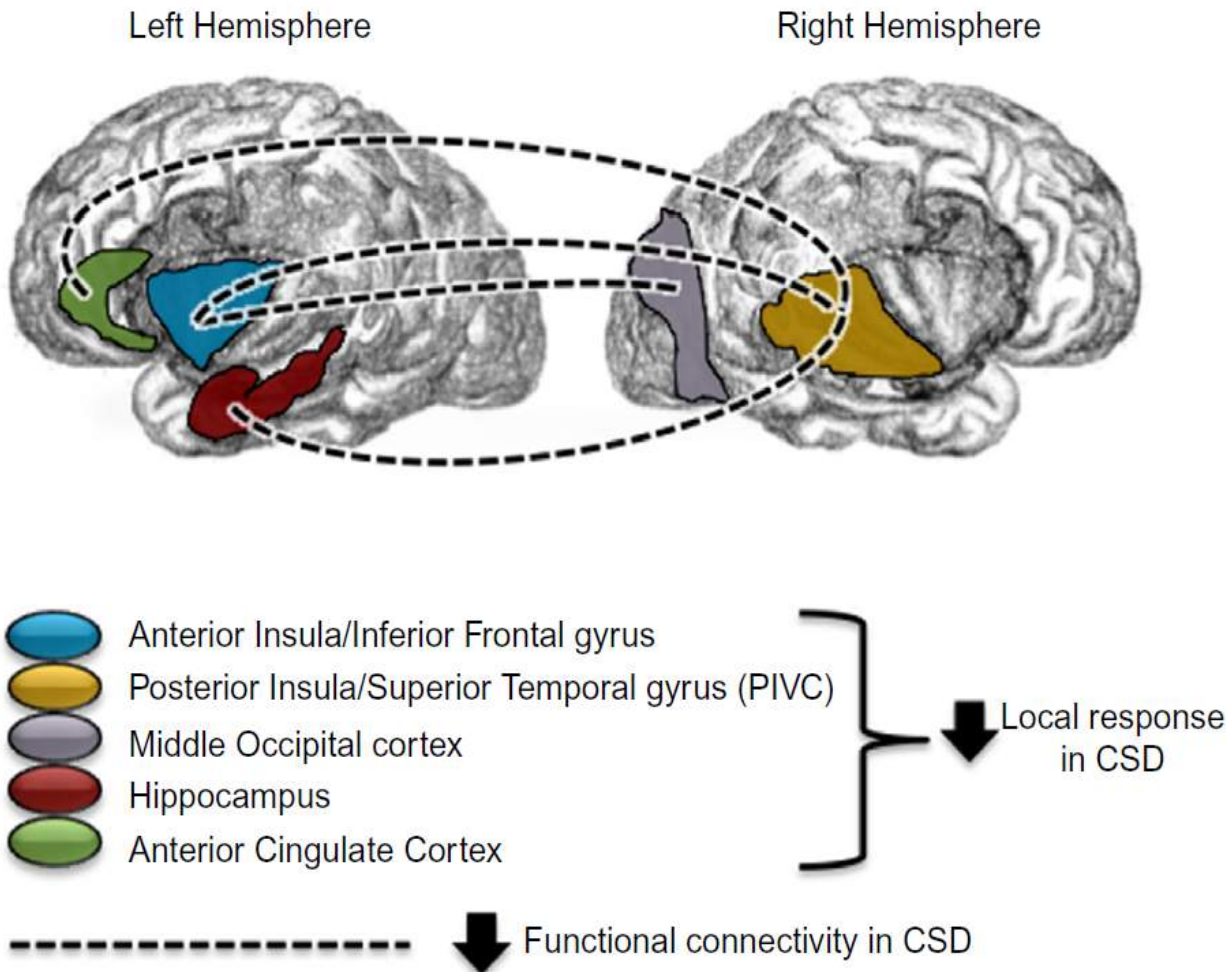
Table 4 Other medical-psychiatric conditions that cause chronic dizziness

	Predisposing factors	Precipitants	Physical symptoms	Psychiatric morbidity	Sustaining factors	Treatments
Neuro-otologic illnesses with comorbid anxiety						
Vestibular migraine	Family history of migraine	Diet, stress, poor sleep	Headache, True vertigo Ataxia, SDI/HM/VV	AA/NA/PA, Panic attacks Generalized anxiety	Sensitization, Conditioning	Migraine prophylaxis, SSRIs, CBT, VBRT
Others (e.g. Ménière's)		Acute stress?	True vertigo Hearing loss Tinnitus, SDI/HM/VV	AA/NA/PA, Panic attacks Generalized anxiety	Vestibular deficit Conditioning	Neuro-otologic treatments, SSRIs, CBT, VBRT
Medical illnesses that mimic CSD						
Post-concussional syndrome	Age (15–40) Sex (male)	Traumatic brain injury or whiplash	SDI/HM/VV, Poor stamina Headache	Depression, Irritability Memory loss	Diffuse axonal injury	Various medications, rehabilitation
Dysautonomia	Age (15–40)	Autonomic challenges; acute stress	Light-headedness, Presyncope SDI/HM/VV	None, NA/AA	Impaired cardiovascular control	Medications, counterpressure [43]
Other psychiatric disorders						
Conversion disorder	Limited coping strategies	Psychological conflict	Unusual gait or stance	Occasional depression	Unresolved conflict	Psychotherapy, Physiotherapy
Factitious disorder	Childhood neglect/chaos	Long pattern of MUPS	Feigned imbalance	Psychological denial	Various	Psychotherapy
Malingering		Opportunistic legal charges	Feigned imbalance	Lying, Deception	Compensation, Legal charges	

AA, anticipatory anxiety; CBT, cognitive behavioral therapy; CSD, chronic subjective dizziness; HM, hypersensitivity to motion stimuli; MUPS, medically unexplained physical symptoms; NA, noxious avoidance; PA, phobic avoidance; SDI, subjective dizziness/imbalance; SSRIs, selective serotonin reuptake inhibitors; VBRT, vestibular and balance rehabilitation therapy; VV, visual vertigo.


Pathophysiologic Mechanisms of CSD
Behavioral Comorbidity
1. Anxiety disorders
2. Phobic disorders
3. Depression
Precipitants
1. Vestibular crisis
2. Medical event
3. Acute anxiety
Predisposing Factors
1. Introverted temperament
2. Pre-existing anxiety
Failure of Readaptation
Perpetuating Loop
Provoking Factors
1. Upright posture
2. Motion
• Self
• Environment
3. Visual demands
• Complexity
• Precision
Acute Adaptation
1. Visual-somatosensory dependence
2. High-risk postural control strategies
3. Environmental vigilance
Recovery
1. Neurotologic
2. Medical
3. Behavioral

Attività e connettività nelle vertigini croniche soggettive



Journal of Vestibular Research 26 (2016) 403–408
DOI 10.3233/VES-160590
IOS Press

Chronic subjective dizziness: Analysis of underlying personality factors

G. Chiarella[a,*], C. Petrolo[a], R. Riccelli[b], L. Giofrè[b], G. Olivadese[b], F.M. Gioacchini[c], A. Scarpa[d], E. Cassandro[d] and L. Passamonti[b,e]

Abstract.

BACKGROUND: Chronic subjective dizziness (CSD) is characterized by persistent dizziness, unsteadiness, and hypersensitivity to one's own motion or exposure to complex visual stimuli. CSD may be triggered, in predisposed individuals with specific personality traits, by acute vestibular diseases. CSD is also thought to arise from failure to re-establish normal balance strategies after resolution of acute vestibular events which may be modulated by diathesis to develop anxiety and depression.

OBJECTIVE: To confirm the role of personality traits linked to anxiety and depression (i.e., neuroticism, introversion, low openness) as predisposing factors for CSD and to evaluate how individual differences in these personality traits are associated with CSD severity.

METHODS: We compared 19 CSD patients with 24 individuals who had suffered from periferal vestibular disorders (PVD) (i.e., Benign Paroxysmal Postural Vertigo or Vestibular Neuritis) but had not developed CSD as well as with 25 healthy controls (HC) in terms of personality traits, assessed via the NEO-PI-R questionnaire.

RESULTS: CSD patients, relative to PVD patients and HCs, scored higher on the anxiety facet of neuroticism. Total neuroticism scores were also significantly associated with dizziness severity in CSD patients but not PVD patients.

CONCLUSIONS: Pre-existing anxiety-related personality traits may promote and sustain the initial etiophatogenetic mechanisms linked with the development of CSD. Targeting anxiety-related mechanisms in CSD may be therefore a promising way to reduce the disability associated with CSD.

Functional dizziness: from phobic postural vertigo and chronic subjective dizziness to persistent postural-perceptual dizziness

1350 7540

Marianne Dieterich[a,b,c] and Jeffrey P. Staab[d]

The prevalence of functional dizziness as a primary cause of vestibular symptoms amounts to 10% in neuro-otology centers. Rates of psychiatric comorbidity in patients with structural vestibular syndromes are much higher with nearly 50% and with highest rates in patients with vestibular migraine, vestibular paroxysmia, and Ménière's disease. Pathophysiologic processes seem to include precipitating events that trigger anxiety-related changes in postural strategies with an increased attention to head and body motion and a cocontraction of leg muscles. Personality traits with high levels of neuroticism and low levels of extraversion appear as risk factors for anxiety and depressive disorders and increased morbidity in functional disorders.

Criteri diagnostici (PPPD)

A. One or more symptoms of dizziness, unsteadiness, or nonspinning vertigo are present on most days for 3 months and more

1. Symptoms are persistent, but wax and wane

2. Symptoms tend to increase as the day processes but may not be active throughout the entire day

3. Momentary flares may occur spontaneously or with sudden movements

B. Symptoms are present without specific provocation but are exacerbated by

1. Upright posture

2. Active or passive motion without regard to direction or position

3. Exposure to moving visual stimuli or complex visual patterns

C. The disorder usually begins shortly after an event that causes acute vestibular symptoms or problems with balance, though less commonly, it develops slowly

1. Precipitating events include acute, episodic, or chronic vestibular syndromes, other neurologic or medical illnesses, and psychological distress

a. When triggered by an acute or episodic precipitant, symptoms typically settle into the pattern of criterion A as the precipitant resolves, but may occur intermittently at first, and then consolidate into a persistent course

b. When triggered by a chronic precipitant, symptoms may develop slowly and worsen gradually

D. Symptoms cause significant distress or functional impairment

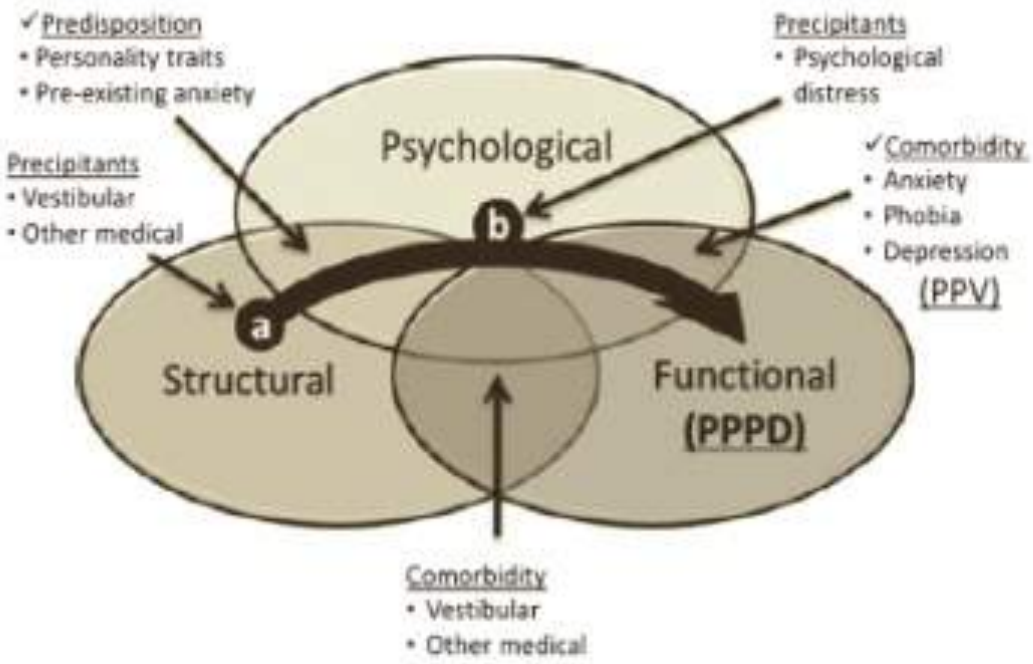
E. Symptoms are not better attributed to another disease or disorder

Journal of Vestibular Research 27 (2017) 191–208
DOI:10.3233/VES-170622
IOS Press

Diagnostic criteria for persistent postural-perceptual dizziness (PPPD): Consensus document of the committee for the Classification of Vestibular Disorders of the Bárány Society

Jeffrey P. Staab[a,*], Annegret Eckhardt-Henn[b], Arata Horii[c], Rolf Jacob[d], Michael Strupp[e], Thomas Brandt[e] and Adolfo Bronstein[f]

MECCANISMO DELLA PPPD




Pergamon

Anxiety Disorders
15 (2001) 27–51

JOURNAL OF Anxiety Disorders

Background and history of the interface between anxiety and vertigo

Carey D. Balaban[a,b,*], Rolf G. Jacob[a,c]

Abstract

The comorbidity of vertigo and anxiety has been an integral component of the medical literature since antiquity. In the works of Plato the same terms were used in the context of vertigo, inebriation, height vertigo, disorientation, and mental confusion. In classical medicine, vertigo had the ambiguous status of being both a disease per se and a symptom of other diseases such as hypochondriacal melancholy. Further, two etiologies were described for vertigo: an origin in the head (brain) and an origin in the hypochondria (abdominal viscera). In the course of the development of a detailed neurologic taxonomy of vertigo in the latter half of the nineteenth century, a debate ensued whether agoraphobia was a form of vertigo or a distinct psychiatric condition. Elucidation of this forgotten debate, within its historical context, provides insights into the recent rediscovery of the balance–anxiety interface.

UN PO DI STORIA…

- 1872 Jackson «vertigo orrible depression»
- 1880 Woakes labirintite :terrore
- 1894 Bach's Nistagmo rotatorio più evidente
- 1900 Freud «anxiety attacks»
- 1951 Hallpike :alterazioni nella risposta calorica
- 1961-63 Collins riflesso oculo-vestibolare alterato
- 1977 Magnusson ,Nilson «equivalenti ansiosi» «Anxiety without anxiety»

RESEARCH PAPER

Psychiatric comorbidity and psychosocial impairment among patients with vertigo and dizziness

Claas Lahmann,[1,2] Peter Henningsen,[1,2] Thomas Brandt,[2,3] Michael Strupp,[2,4] Klaus Jahn,[2,4] Marianne Dieterich,[2,4,5] Annegret Eckhardt-Henn,[6] Regina Feuerecker,[2,4] Andreas Dinkel,[1] Gabriele Schmid[1,2]

J Neurol Neurosurg Psychiatry 2014;**0**:1–7.

Methods This cross-sectional study involved a sample of 547 patients recruited from a specialised interdisciplinary treatment centre for vertigo/dizziness. Diagnostic evaluation included standardised neurological examinations, structured clinical interview for major mental disorders (SCID-I) and self-report questionnaires regarding dizziness, depression, anxiety, somatisation and quality of life.

Results Neurological diagnostic workup revealed organic and non-organic vertigo/dizziness in 80.8% and 19.2% of patients, respectively. In 48.8% of patients, SCID-I led to the diagnosis of a current psychiatric disorder, most frequently anxiety/phobic, somatoform and affective disorders. In the organic vertigo/dizziness group, 42.5% of patients, particularly those with vestibular paroxysmia or vestibular migraine, had a current psychiatric comorbidity. Patients with psychiatric comorbidity reported more vertigo-related handicaps, more depressive, anxiety and somatisation symptoms, and lower psychological quality of life compared with patients without psychiatric comorbidity.

Conclusions Almost half of patients with vertigo/dizziness suffer from a psychiatric comorbidity. These patients show more severe psychosocial impairment compared with patients without psychiatric disorders. The worst combination, in terms of vertigo-related handicaps, is having non-organic vertigo/dizziness and psychiatric comorbidity. This phenomenon should be considered when diagnosing and treating vertigo/dizziness in the early stages of the disease.

J Neurol (2009) 256:58–65
DOI 10.1007/s00415-009-0038-8

ORIGINAL COMMUNICATION

Christoph Best
Annegret Eckhardt-Henn
Regine Tschan
Marianne Dieterich

Psychiatric morbidity and comorbidity in different vestibular vertigo syndromes

Results of a prospective longitudinal study over one year

Methods This interdisciplinary prospective longitudinal study included a total of 68 patients with vestibular vertigo syndromes. Four subgroups were compared: benign paroxysmal positioning vertigo (BPPV, n = 19), vestibular neuritis (VN, n = 14), vestibular migraine (VM, n = 27), and Menière's disease

Conclusion A positive history of psychiatric disorders is a strong predictor for the development of reactive psychiatric disorders following a vestibular vertigo syndrome. Especially patients with vestibular migraine are at risk of developing somatoform dizziness. The degree of vestibular dysfunction does not correlate with the development of psychiatric disorders.

Anxiety disorders and other psychiatric subgroups in patients complaining of dizziness

A. Eckhardt-Henn[a,*], P. Breuer[b], C. Thomalske[c], S.O. Hoffmann[a], H.C. Hopf[c]

Anxiety Disorders
17 (2003) 369–388

CASISTICA

- 189 PAZIENTI
- 50 (ORGANICI)→
- 30 (MISTI)
- 99(PSICHIATRICI)
- 10(IDIOPATICI.)

Neurologic diagnoses

Diagnosis	Mixed group (*N* 30)	Organic group (*N* 50)
Peripheral vestibular lesion	13	20
Benign paroxysmal positioning vertigo	2	7
Menière's disease	4	
Central lesion	3	2
Basilar artery migraine		4
Inflammated CNS-disease	1	2
Commotio labyrinthii		5
Neurinoma lumbar spine		1
Brainstem contusion		1
Arachnoidal intracerebral cyst	2	
Megalodolichobasilaris	1	
Alport syndrome	1	
Cholesteatoma	1	
Cervical syndrome	1	
Parkinson's disease		1
Transient ischemic attack	2	6
Acusticus neurinoma		1

CNS: Central Nervous System.

Psychiatric (DSM-IV) diagnoses

DSM-IV diagnosis	Psychiatric group (*N* 99)	Mixed group (*N* 30)
Depressive disorders		
296.2 Major depression, single episode	10	4
296.3 Major depression, recurrent episode		1
311 Depressive disorder, NOS	2	1
309.0 Adjustment disorder with depressed mood	1	1
Anxiety disorders		
300.01 Panic disorder without agoraphobia	7	1
300.21 Panic disorder with agoraphobia	11	3
300.22 Agoraphobia	3	
33.02 Generalized anxiety disorder	11	3
300.00 Anxiety disorder NOS	13	4
Somatoform disorders		
300.81 Somatization disorder	2	2
300.81 Undifferentiated somatoform disorder	1	
300.81 Somatoform disorder, NOS	13	2
300.11 Conversion disorder	25	8

NOS: Not otherwise specified.

Psychological distress longitudinally mediates the effect of vertigo symptoms on vertigo-related handicap

Thomas Probst [a,b,*], Andreas Dinkel [c], Gabriele Schmid-Mühlbauer [d], Katharina Radziej [c,e], Karina Limburg [c,e], Christoph Pieh [f,g], Claas Lahmann [c,e,h]

[a] Department of Psychology and Psychotherapy, Witten/Herdecke University, Witten, Germany

Journal of Psychosomatic Research 93 (2017) 62–68

Objective: Vertigo symptoms can lead to more or less vertigo-related handicap. This longitudinal study inves gated whether depression, anxiety, and/or somatization mediate the relationship between vertigo symptor and vertigo-related handicap.
Methods: $N = 111$ patients with vertigo/dizziness provided complete data on the following measures: Verti symptoms at baseline, depression at 6-month follow-up, anxiety at 6-month follow-up, somatization at month follow-up, and vertigo handicap at 12-month follow-up. Mediation analyses with bootstrapping we performed to investigate the mediating role of anxiety, depression, and somatization in the relationship betwe vertigo symptoms and vertigo-related handicap.
Results: When the mediating role of anxiety, depression, and somatization was evaluated separately from ea other in single mediation models, the effect vertigo symptoms at baseline exerted on vertigo-related handic at 12-month follow-up was significantly mediated by depression at 6-month follow-up ($p < 0.05$), by anxie at 6-month follow-up ($p < 0.05$), as well as by somatization at 6-month follow-up ($p < 0.05$). When statistica controlling for the other mediators in a multiple mediator model, only depression at 6-month follow-up medi ed the effect of vertigo symptoms at baseline on vertigo-related handicap at 12-month follow-up ($p < 0.05$).
Conclusion: Psychological distress is an important mechanism in the process how vertigo symptoms lead to ve tigo-related handicap.

Journal of Psychosomatic Research 76 (2014) 80–83

Contents lists available at ScienceDirect

Journal of Psychosomatic Research

Short communication

Anxious, introverted personality traits in patients with chronic subjective dizziness

Jeffrey P. Staab [a,*], Daniel E. Rohe [a], Scott D.Z. Eggers [b], Neil T. Shepard [c]

ABSTRACT

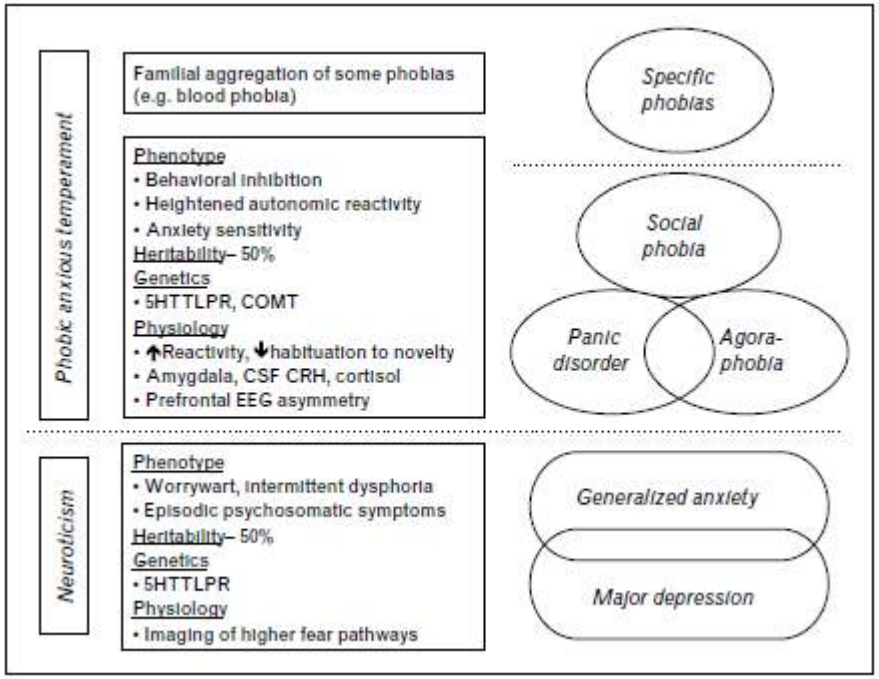
Objectives: Chronic subjective dizziness (CSD) is a neurotologic disorder of persistent non-vertiginous dizziness, unsteadiness, and hypersensitivity to one's own motion or exposure to complex visual stimuli. CSD usually follows acute attacks of vertigo or dizziness and is thought to arise from patients' failure to re-establish normal locomotor control strategies after resolution of acute vestibular symptoms. Pre-existing anxiety or anxiety diathesis may be risk factors for CSD. This study tested the hypothesis that patients with CSD are more likely than individuals with other chronic neurotologic illnesses to possess anxious, introverted personality traits.

Methods: Data were abstracted retrospectively from medical records of 40 patients who underwent multidisciplinary neurotology evaluations for chronic dizziness. Twenty-four subjects had CSD. Sixteen had chronic medical conditions other than CSD plus co-existing anxiety disorders. Group differences in demographics, Dizziness Handicap Inventory (DHI) scores, Hospital Anxiety and Depression Scale (HADS) scores, DSM-IV diagnoses, personality traits measured with the NEO Personality Inventory — Revised (NEO-PI-R), and temperaments composed of NEO-PI-R facets were examined.

Results: There were no differences between groups in demographics, mean DHI or HADS-anxiety scores, or DSM-IV diagnoses. The CSD group had higher mean HADS-depression and NEO-PI-R trait anxiety, but lower NEO-PI-R extraversion, warmth, positive emotions, openness to feelings, and trust (all $p < 0.05$). CSD subjects were significantly more likely than comparison subjects to have a composite temperament of high trait anxiety plus low warmth or excitement seeking.

Conclusion: An anxious, introverted temperament is strongly associated with CSD and may be a risk factor for developing this syndrome.

RELAZIONE TRA TEMPERAMENTO,MECC. FISIOPATOLOGICO, DISTURBO FOBICO, PANICO E DI ANSIA



Current Opinion in Neurology 2006, 19:41–48

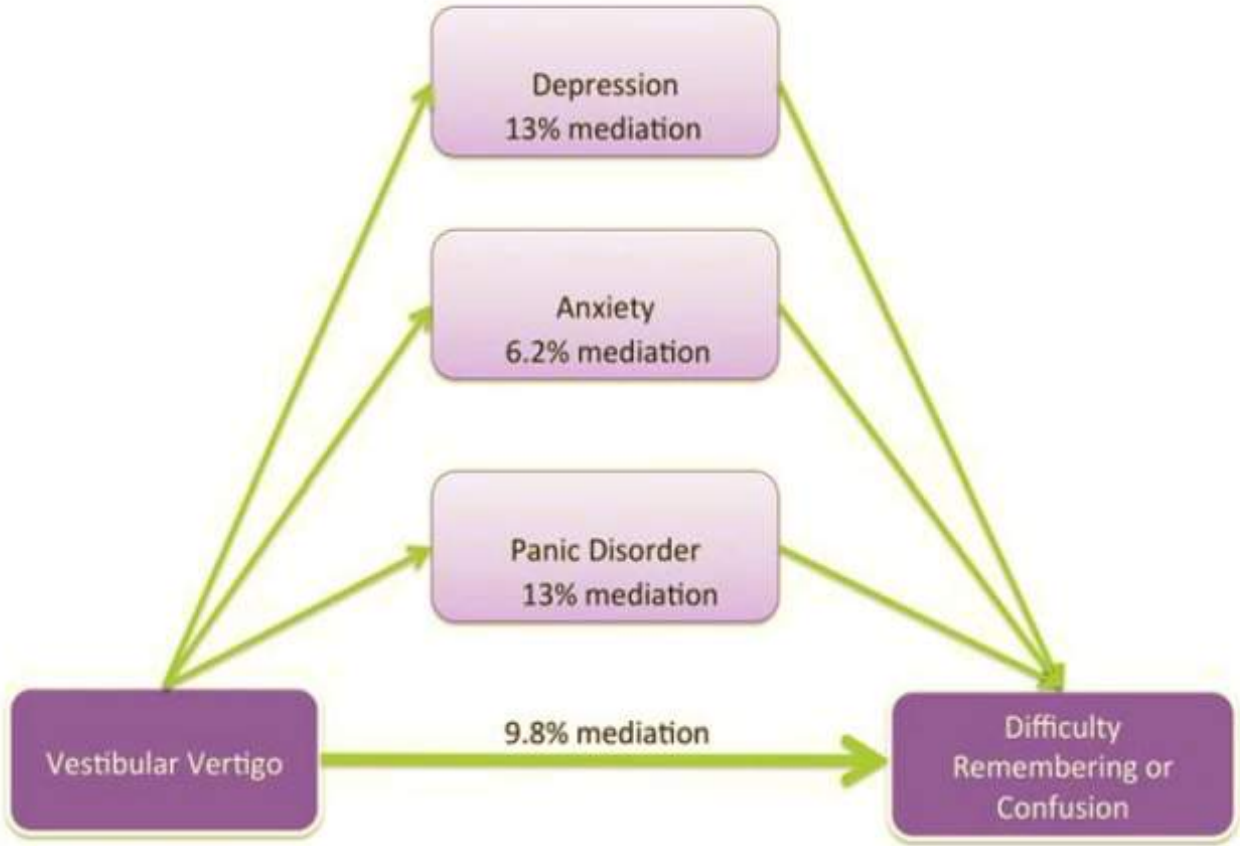
RESEARCH PAPER

Vestibular vertigo and comorbid cognitive and psychiatric impairment: the 2008 National Health Interview Survey

Robin T Bigelow,[1] Yevgeniy R Semenov,[1] Sascha du Lac,[1,2] Howard J Hoffman,[3] Yuri Agrawal[1]

J Neurol Neurosurg Psychiatry 2015;**0**:1–6.

Conclusions Our findings indicate that vestibular impairment is associated with increased risk of cognitive and psychiatric comorbidity. The vestibular system is anatomically connected with widespread regions of the cerebral cortex, hippocampus and amygdala. Loss of vestibular inputs may lead to impairment of these cognitive and affective circuits. Further longitudinal research is required to determine if these associations are causal.



Combined, depression, anxiety, and panic disorder account for 32% of the effect of vestibular vertigo on difficulty remembering or confusion

CENNI DI TERAPIA

- S.S.R.I. (sertralina,seropram,escitalpram)
- S.N.R.I (venlafaxina)
- Approccio psicoterapeutico (cognitivo-comportamentale)
- Evitare benzodiazepine!

Journal of Psychosomatic Research 105 (2018) 21–30

Contents lists available at ScienceDirect

Journal of Psychosomatic Research

journal homepage: www.elsevier.com/locate/jpsychores

Effects of a program of cognitive-behavioural group therapy, vestibular rehabilitation, and psychoeducational explanations on patients with dizziness and no quantified balance deficit, compared to patients with dizziness and a quantified balance deficit

D.A. Schmid[a,d], J.H.J. Allum[a,b,*], M. Sleptsova[a], S. Gross[a,c], J. Gaab[c], A. Welge-Lüssen[b], R. Schaefert[a], W. Langewitz[a]

KEY POINTS

- Functional and psychiatric causes of vestibular symptoms are common and can be identified by readily recognizable patterns of symptoms.
- The term 'functional' now refers, as it once did, to conditions that arise from changes in the functioning of organ systems, rather than from structural defects or psychiatric disorders, which are separate entities.
- The Bárány Society and WHO recently defined a new functional vestibular disorder termed 'persistent postural-perceptual dizziness' (PPPD) based on 3 decades of research on phobic postural vertigo, space-motion discomfort, visual vertigo, and chronic subjective dizziness.
- Functional and psychiatric vestibular disorders may be treated successfully with systematic applications of patient education, physiotherapy, cognitive behavior therapy, and medications.

TAKE HOME MESSAGE

- LE SINDROMI VERTIGINOSE SONO UN ESEMPIO PERFETTO DI COME L'APPROCCIO DIAGNOSTICO E TERAPEUTICO MAI COME ORA DEBBA ESSERE MULTI-INTERDISCIPLINARE.
- L'OTORINO, IL NEUROLOGO, LO PSICHIATRA RAPPRESENTANO LE FIGURE DI RIFERIMENTO E LA LORO CONDIVISIONE DI INTENTI NON PUO' E NON DEVE CHE ESSERE AUSPICABILE